In the Specification

At page 1, lines 7 – 22 and page 2, lines 1 – 2, please replace the paragraph as follows (underlined denotes replacements additions and strikethough/double brackets notes deletions):

Congestive heart failure (CHF) is a condition in which the heart is unable to pump enough blood to meet the metabolic needs of a patient's body. The condition results in the patient having shortness of breath, weakness and a lack of stamina, fatigue, exercise intolerance and fluid retention which results from an inadequate flow of blood to the patient's kidneys. CHF is a progressive disease that involves the continuing enlargement of the heart muscle in response to the low blood output (cardiac output). The harder the heart works to pump more blood, the more enlarged it becomes. The more enlarged the heart becomes, the more work the heart must do to pump the same amount of blood. The progressive cycle of the disease has few symptoms until the heart is unable to do more work. Often, by the time symptoms are noticed by the patient, the enlargement is pronounced and the heart is unable to provide enough cardiac output to support normal lifestyle activity. Drug treatments that attempt to increase cardiac output tend to facilitate the progression of the disease. Conversely, drug treatments that lower cardiac output tend to slow the progression of the disease. However, this can severely limit the patient's lifestyle, leaving many patients effectively immobile or worse. Many CHF ~~patient's~~patients require extensive and expensive treatments both on an in-patient and out-patient basis.

At page 2, lines 13 – 19, please replace the paragraph as follows (underlined denotes replacements additions and strikethough/double brackets notes deletions):

Others have attempted to treat CHF by placing pacing leads in the right heart (RA and/or RV) and on the outside of the LV. These pacing leads are connected to a power source that supplies electrical signals to the right heart and to the LV to cause them to contract in the normal manner. This has been found to be effective in controlling cardiac contractions. However, placing the pacing lead on the outside of the LV requires a surgical procedure which is both expensive and risky, especially given the weakened condition of CHF patients.

At page 2, lines 20 – 24 and page 3, lines 1 – 6, please replace the paragraph as follows (underlined denotes replacements additions and strikethough/double brackets notes deletions):

The present assignee, Guidant Corporation, has recently introduced a treatment for CHF wherein a pacer lead for the LV is advanced through the ostium or opening of the coronary sinus (located in the RA) and into the venous drainage system of the LV which drains into the coronary sinus. This allows the RA and/or RV and LV pacer lead placement for CHF treatment utilizing the less invasive and less risky percutaneous catheterization procedures used to position the RA and/or RV lead(s) in conventional pacing. Thus many more CHF patients with conduction abnormalities can be treated. This procedure has been found to greatly enhance the heart's pumping efficiency and to increase the patient's cardiac output to the extent that the patient can frequently resume normal daily activity and/or benefit from drug therapy.

At page 4, lines 5 – 17, please replace the paragraph as follows (underlined denotes replacements additions and strikethough/double brackets notes deletions):

Once placed within the coronary sinus, the distal tip of the guiding catheter can be easily dislodged during the subsequent advancement of a guidewire into position within the vasculature of the coronary sinus which is employed to ~~delivery~~deliver the pacing lead into the coronary sinus. The tip may be easily dislodged, because it is unlikely that the shape of the distal portion of the guiding catheter will match the shape of the RA closely enough to provide good support (resist guiding catheter tip movement). Also the orientation of the distal tip of the guiding catheter may not match the take off curve or angle of the coronary sinus, causing any inserted devices to immediately contact the wall of the coronary sinus. Thus, as a guidewire is manipulated and advanced through the guiding catheter into the coronary sinus, the force that the guidewire applies to the wall of the guiding catheter may push the distal tip of the guiding catheters out of the ostium. This may result in a damaged guidewire and/or loss of access to the coronary sinus.

At page 6, lines 5 – 8, please replace the paragraph as follows (underlined denotes replacements additions and strikethough/double brackets notes deletions):

In an alternate embodiment, the tubular support member may include a tendon or tendons and [[a]] perhaps a shaping member in conjunction with a suitable tendon control device to allow the physician to adjust [[of]] the angle of its shaped distal end.

At page 16, lines 17 – 24 and pate 17, lines 1 – 9, please replace the paragraph as follows (underlined denotes replacements additions and strikethough/double brackets notes deletions):

A distal portion of a pacing lead 73 is shown in Fig. 11 disposed within the patient's cardiac vein 75 disposed on the left side 76 of the patient's heart adjacent to the patient's left ventricle (not shown). The pacing lead 73 is generally ~~to~~too large to be introduced into the accessing system, so as a result, a guidewire ~~is~~ may be introduced through the guide member 31 when its distal end is disposed within the coronary sinus ostium. The accessing system may then be removed leaving the guidewire in place. A guiding catheter having a larger inner lumen may then be advanced over the guidewire left in place to provide a more distal access within the coronary ostium. A first guidewire may then be removed and a second guidewire having greater steerability may then be advanced through the larger guiding catheter to the desired location within the patient's cardiac vein 75. The pacing lead 73 may then be advanced over the second guidewire to the desired location within the vein 75 as shown in Fig. 11. The pacing lead 73 is provided with an electrode 77 on its distal end which is utilized to pace the left ventricle. Additionally, other pacing leads may also be used to pace other portions of the patient's heart. In this manner the hearts of patient's with CHF can be effectively controlled with the one or more pacing leads to improve blood output from the left and right ventricles.

At page 17, lines 16 – 24 and page 18, lines 1 – 10, please replace the paragraph as follows (underlined denotes replacements additions and strikethough/double brackets notes deletions):

Fig. 11 illustrates the installed system in a heart having a normal shape. As mentioned above, the hearts of CHF patients can be enlarged and deformed which makes accessing the patient's coronary ostium difficult and time consuming for the physician. Fig. 12 illustrates systematic steps for guiding the distal end of the guiding member 31 into the ostium 72 of the

patient's coronary sinus particularly when the heart chamber is deformed or enlarged. The assembly is disposed in the right atrium 68 of the patient with the distal portion 53 of the stabilizer 50 disposed in the apex 71 of the right ventricle 70. The tubular support member 10 is rotated about the stabilizer 50 with the distal section 44 of the guiding member 31 extending out the distal port 25 toward the wall of the right atrium 68. In this manner the distal section 44 can sweep against a wide region of the atrial wall as shown by the arrows 78 in a sequential pattern to ensure rapid accession of the coronary ostium 72. After each sweep, the tubular support member 10 can be moved along (up or down) the shaft of the stabilizing member 50 so that a region of the atrial wall can be systematically explored. The electrode 43 (shown on Fig. 5) on the distal end of the guiding member 31 can be employed by comparing its EKG output with that of a standard electrode to allow the physician to determine its position within the atrial chamber. Different locations within the right atrium provide different signal characteristics which the physician can se to determine the electrode's location.

At page 19, lines 20 – 23 and page 20, lines 1 – 2, please replace the paragraph as follows (underlined denotes replacements additions and strikethough/double brackets notes deletions):

While not ~~show~~shown in the drawings, the tubular support member may be delivered to the right atrium through a guiding catheter. Moreover, it will be apparent from the foregoing that, while particular forms of the invention have been illustrated and described, various modifications can be made without departing from the spirit and scope of the invention. Those skilled in the art will also recognize that features shown in one embodiment may be utilized in other embodiments.